Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CY-FAIR CHIROPRACTIC ASSOC

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number
M4-17-1068-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
DECEMBER 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary was not submitted.

Amount in Dispute: $2,135.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that a large number of the charges listed on the DWC060 have been paid at fee schedule."

Response Submitted by: Flahive, Ogden & Latson/Starr Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12, 2016 April 19, 2016 May 3, 2016 May 5, 2016	CPT Code 99212-25 Office Visit	$75.00	$0.00
April 12, 2016 April 19, 2016 April 27, 2016 May 3, 2016 May 5, 2016	CPT Code 98940 Chiropractic Manipulation, Spinal 1-2 regions	$55.00	$0.00
April 12, 2016 April 19, 2016 May 5, 2016	CPT Code 97140-59-GP Manual Therapy Techniques	$55.00	$0.00
April 12, 2016 April 19, 2016 May 5, 2016	CPT Code 97110-GP-59 Therapeutic Procedures	$55.00	$0.00
April 12, 2016 April 19, 2016 May 5, 2016	CPT Code 97530-GP-59 Therapeutic Activities	$65.00	$0.00
April 12, 2016 April 19, 2016 May 5, 2016	CPT Code 97112-GP-59 Therapeutic Procedure	$55.00	$0.00

April 12, 2016 April 19, 2016 April 27, 2016 May 3, 2016 May 5, 2016	CPT Code 98943-51 Chiropractic Maipulation, Extraspinal 1 or more regions	$58.00	$0.00
April 27, 2016	CPT Code 99213-25 Office Visit	$145.00	$0.00
April 27, 2016 May 3, 2016	CPT Code 99354-25 Prolonged Evaluation and Management Service	$180.00	$0.00
May 3, 2016	CPT Code 99080-73 Work Status Report	$20.00	$0.00
TOTAL		$2,135.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
6. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
7. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
8. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
9. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 150-Per CMS, in the office or other outpatient setting, Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP.
   - W3-Additional payment made on reconsideration.
   - 193-Original payment decision is being maintained. This claimw as processed properly the first time.
   - W3/193-per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Orignal payment decision is being maintained.
   - 151-Payment adjusted because the payer deems the information submitted does not support this many services.
   - 151-There is not time spent documented to support the prolonged phsycian service requiring direct (face-to-face) patient contact.
   - 29-The time limit for filing has expired.
   - 29-Per rule 133.20(b), except as provided in Labor Code 408.0272(b), (c) or (d), a health care provider shall not submit a medical b ill later than the 95th day after the date the services are provided.
   - P14-The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
   - P14-Reports are global of the evaluation and management service. No modifiers used.
   - 18-Duplicate claim/service.

- 18-Duplicate charge(s). Previously audited and payment denied. If reconsideration is desired a request for reconsideration myst be filed in accordance with rule 133.250(d) and must be filed no later than ten months from the date of service.

Issues

1. Does a timely filing issue exist for date of service May 5, 2016?
2. Does the documentation support billing CPT code 99080-73?
3. Does the documentation support billing CPT code 99354-25?
4. Is the requestor entitled to additional reimbursement for services rendered April 12, April 19, April 27, and May 3, 2016?

Findings

1. The respondent denied reimbursement for services rendered on May 5, 2016 based upon "29-The time limit for filing has expired," and "29-Per rule 133.20(b), except as provided in Labor Code 408.0272(b), (c) or (d), a health care provider shall not submit a medical b ill later than the 95th day after the date the services are provided."

   Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation finds that the requestor did not submit a fax confirmation, personal delivery or electronic transmission or a postmark letter to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a).

   The division concludes that the requestor did not sufficiently support that the disputed bills for date of service May 5, 2016 were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended

2. The respondent denied reimbursement for CPT code 99080-73 based upon "29-The time limit for filing has expired," "29-Per rule 133.20(b), except as provided in Labor Code 408.0272(b), (c) or (d), a health care provider shall not submit a medical b ill later than the 95th day after the date the services are provided," "P14-The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day," and "P14-Reports are global of the evaluation and management service. No modifiers used."

   Regarding the timely filing issue, the requestor did not sufficiently support that the disputed bill for CPT code 99080-73 was submitted timely in accordance with Texas Labor Code §408.027(a).

   In addition to denying payment for code 99080-73 based upon timely filing, the respondent raised the issue that payment for the report was global to evaluation and management code.

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   On the disputed date of service, the requestor billed codes 99212-25, 98940, 98943, 99354-25 and 99080-73.

   CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form." The requestor appended modifier 73 to identify the report and billing was for a work status report. Because the requestor appended a workers' compensation specific modifier, the applicable fee guidelines is 28 Texas Administrative Code §134.204.

   28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i)

and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:
(1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

A review of the submitted documentation finds that the requestor did not submit a copy of the work status report to support billing. As a result, reimbursement is not recommended.

3. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99354 based upon "151-Payment adjusted because the payer deems the information submitted does not support this many services, "150-Payment adjusted because the payer deems the information submitted does not support this level of service," "150-Per CMS, in the office or other outpatient setting, Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP," and "151-There is not time spent documented to support the prolonged phsycian service requiring direct (face-to-face) patient contact."

   April 27, 2016 the requestor billed CPT codes 99354-25 with 99213-25. These codes are defined as

   - 99354 - "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)."
   - 99213-"Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   A review of the submitted documentation finds that the requestor's documentation of time spent in direct contact with patient did not support billing CPT code 99354 in addition to the evaluation and management code; therefore, reimbursement is not recommended.

   May 3, 2016 the requestor billed CPT codes 99354-25 with 99212-25. These codes are defined as

   - 99354 - "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)."
   - 99212-"Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family."

   A review of the submitted documentation finds that the requestor's documentation of time spent in direct contact with patient did not support billing CPT code 99354 in addition to the evaluation and management code; therefore, reimbursement is not recommended.

4. The Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the

established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77065, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

Using the above formula, the Division finds the following:

Dates of Service	CPT Codes	Medicare Participating Amount	MAR	Amount Paid	Amount Due
April 12, 2016 April 19, 2016 May 3, 2016	99212-25	$44.09	$69.97	$69.97/ea	$0.00
April 12, 2016 April 19, 2016 April 27, 2016 May 3, 2016	98940	$28.99	$46.01	$46.01/ea	$0.00
April 12, 2016 April 19, 2016	97140	$30.44	$48.31	$48.31/ea	$0.00
April 12, 2016 April 19, 2016	97110	$32.95	$52.29	$52.29/ea	$0.00
April 12, 2016 April 19, 2016	97530	$35.49	$56.32	$56.32/ea	$0.00
April 12, 2016 April 19, 2016	97112	$34.39	$54.58	$54.58/ea	$0.00
April 12, 2016 April 19, 2016 April 27, 2016 May 3, 2016	98943	Not priced by Medicare	F&R	$44.26/ea	$0.00

Because CPT code 98943 is not priced by Medicare the division refers to 28 Texas Administrative Code §134.203(f) which states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

The requestor is seeking $58.00 for CPT code 98943. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." A review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $58.00 for CPT code 98943 would be a fair and reasonable rate of reimbursement. As a result reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		2/9/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.